EXECUTIVE SUMMARY

Assessment of Family Planning Counseling Within Selected Reproductive Health Services

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Research Objectives and Methodology

1. The current concern for "quality of care" underscores clients' needs and expectations in family planning and bringing them back to the center of family planning service provision. The provision of quality family planning counseling could contribute to overall client satisfaction and improved continuation rates. Effective client-provider communication and counseling in family planning, therefore, is a centerpiece in high quality family planning service provision. It is essential in mapping out a client-centered and quality- focused programme strategy.

2. This nationwide study assesses the quality of family planning counseling currently provided in both the public and private service delivery points, specifically the public rural health units/city health centers and the private clinics managed and/or affiliated with NGOs. It addresses the following questions/ issues: (1) What is the current status of family planning counseling process and how effective is it in addressing health concerns/fears of side-effects/rumors and misconceptions?; (2) Does the counseling process follow the standards which are demonstrated and specified in the
" GATHER" approach?; and (3) How do stakeholders view their role in FP counseling and what suggestions do they have for improving FP counseling?

3. The study aims: (a) to conduct an inventory and review of the past researches done on family planning counseling in the Philippines; (b) to review the variants and common elements of the GATHER modules designed by JHU/CCP, UNFPA and EngenderHealth; (c) to assess the actual FP counseling provision, behaviors and practices from the viewpoints of the different stakeholders, specifically the clients, non-clients, health service providers, supervisors, local government officials and selected leaders of the community; (d) to identify strengths, weaknesses and gaps of FP counseling performance; and (5) to make recommendations to strengthen the FP counseling performance in both public and private health facilities.

4. The research covered 28 public rural health units/city health centers and NGO private clinics from eight (8) areas in the country, and the selection was based on their level of CPR performance as indicated in the 2000 NSO Family Planning Survey. **For high performing**

areas, the areas included were: (a) Pampanga (San Fernando and Angeles City), (b) Bacolod City, (c) Davao City, (d) Quezon City. **For low performing areas**, the sites consisted of: (a) Rizal, (b) Tacloban City (c) Butuan City, and (d) Pasay City.

5. Data collection methods used by the study included: (a) face-to-face semi-structured interviews with clients; (b) face-to-face semi-structured interviews with non-clients; (c) in-depth interviews with providers; (d) in-depth interviews with clinic heads/supervisors; (e) facility observation; (f) structured stakeholder meetings with local managers, providers, clients, supervisors and barangay leaders/official; and (g) use of audio-tapes to capture actual FP counseling/ communication process occurring in the facility.

6. The tools used in gathering the data were: (a) interview schedule for clients; (b) interview schedule for non-clients; (c) interview schedule for health service providers; (d) interview schedule for the supervisors/heads of facilities; (e) FP Observation Tool (Quick Investigation of Quality Tool); (f) Stakeholders' Agenda and Matrix Tool.

7. The respondents consisted of: (a) 280 clients of whom 3.9% were males; (b) 280 non-clients of whom 18.2% were males; (c) 30 health service providers; and (d) 24 facility heads/supervisors. In addition, 42 observations and audio-taping of FP counseling sessions were undertaken.

Summary of Empirical Findings

1. Clients are generally middle-aged with a mean age of 30 years; clients of private clinics are relatively older (mean=31.56) when compared with those in the public health centers (mean age is 29). Most of the clients are married (95%) and have an average of 2.62 living children. About 4% of the respondents are males/husbands. A greater proportion of clients from public health facilities are unemployed (37.5%) when compared to those in private clinics (33.2%). Clients of private clinics are much more highly educated, with 27% having reached and/or graduated from college as compared to those of the public health facilities; and 27% of clients from public health facilities having reached and/or graduated from high school. Approximately nine (9) out of ten (10) are Catholics.

2. Non-clients are generally middle-aged with an average age of 32 years. Most are married (89.7%) with an average of 2.60 living children. Males comprise 18.2%; employed respondents comprise 60.7%, self-employed, 20.4%. About 15.7% are employed in the

private sector; more than half the non-client respondents have reached and/or completed secondary schooling (53.3%) and one-third (30.7%) have reached and/or completed college. Approximately 9 out of 10 non-client respondents are Catholics.

3. Health service providers are also middle aged with a mean age of 39 years; providers from public health facilities are much older (mean=40) than those in the private (mean=37) clinics. Providers are predominantly females; most are married and have attained college degrees in medicine and allied professions. Most are also Catholics. Most of those interviewed in public health facilities are midwives and nurses and have been in the service for 7 years and longer. Those in private facilities are FP counselors and clinic managers/supervisors.

4. Supervisors are mostly females with an average age of 43 years; supervisors from public facilities are much older (mean=44) than those in the private facilities (mean=42). Most are married and Catholics; they are either physicians or nurses and have stayed long in the health profession.

5. Among the clients, results revealed a very positive picture of the manner in which FP counseling is being conducted in the various sites of the research. Clients provided mostly positive descriptions of their FP counseling providers and these were mostly in the interpersonal skill domain - e.g., providers were good counselors, kind and good-natured, showed good attitude, and were accommodating. Majority of the respondents indicated that their FP counseling providers encouraged them to ask questions during their sessions. Clients from both public and private clinics characterized their providers as good listeners, understanding, helpful, and trustworthy. These were observed in clients of both private and public service delivery points.

6. In describing the qualities or characteristics of a good FP counseling provider, clients cited responses focusing on the domains of depth of knowledge on Family Planning and good counseling skills. They indicated that the FP counseling provider should be knowledgeable, should give correct information about Family Planning, must give good explanations, and must be able to answer all questions of clients. In contrast to popular notions and the findings of previous studies, respondents of this study consider both interpersonal skills and competency in delivering complete and accurate information about Family Planning (cognitive skills) in their assessment of their service providers. Clients' responses indicate a bias for counselors who are confident and competent in delivering information regarding FP.

7. Respondents identified the providers' behaviors that they liked during FP counseling sessions as good explanations given by the providers about FP, the positive attitude shown to them, and the good advice given to them. All these reflect a combination of good knowledge and good interpersonal skills.

8. A good number of respondents indicated that they actively asked questions during their counseling sessions and the questions posed primarily involved clarifications about FP methods and obtaining additional knowledge. Majority of the client respondents also claimed that they were given ample time for the counseling to transpire. They mentioned that the session allowed them to secure all the information they needed from their providers, and that the provider was able to explain all the methods well.

9. Respondents expect to be warmly welcomed by their providers, treated with respect, and given complete information during the FP counseling session. They indicated that they would feel more comfortable about asking questions during a session if they were in a private room and if their service provider was friendly, a good listener, approachable, and able to answer most of their questions.

10. Attributes of an ideal client during an FP counseling session as cited by clients were: they should show respect to the providers, be cooperative, and ask questions. An ideal FP counseling provider was characterized as being someone who possesses the good interpersonal behaviors expected of a counselor such as being kind and good-natured, accommodating, and smiling. Respondents also mentioned that a skillful FP counseling provider should be knowledgeable about FP matters and also exhibit good counseling skills. Specifically, non-clients mentioned that if they ever do avail of FP counseling, they expect the FP counselors to explain the different methods well, give good advice, and stay friendly even under pressure.

11. Although 26 out of 30 of the provider respondents have heard of GATHER, only 3 reported that this is consistently practiced when regularly counseling the clients. The rest either use the GATHER sporadically or do not follow it at all.

12. Using GATHER as a framework for the analysis and evaluation, results indicate that in general, providers' performance in terms of FP counseling is far from what is expected. Rating outcomes indicate that providers yielded low scores in terms of following the sequence specified in the GATHER standard. Findings also demonstrate that providers were

rated moderately in the following aspects: (a) providing useful and accurate information; and (b) helping the client understand the information given her/him. Providers need strengthening in the following aspects as they yielded low rating scores: (a) inviting clients to bring others to the clinic; (b) exploring the need for STD/HIV prevention; (c) discussing STD prevention and giving condoms, if needed; (d) explaining any printed instructions and giving them to the client; (e) asking about feelings; (f) assuring clients of confidentiality; and (g) telling the client what to expect from the counseling. The sequence of the GATHER approach was not properly followed by the service providers.

13. Asking of open-ended questions on the part of the providers was least practiced in the FP counseling sessions. The predominance of the raising of closed-ended questions reflects more direct information gathering and does not allow the occurrence of deeper discussions. Although more questions were asked by the providers during the counseling, these were geared towards information gathering rather than towards helping the client further explore her concerns and feelings with guidance from the counselors. Certain behaviors were shown by the providers that seem to indicate the providers' inability to follow the client-oriented interaction, as noted in the audio-taped counseling sessions. Examples of these behaviors were: shouting during the session, laughing at clients, directly or indirectly making of fun of a client's response, bombarding clients with a series of questions, not allowing clients to talk, cutting clients off in the middle of their statements, avoiding answering questions, and giving of vague answers.

14. Misconceptions were also noted during the FP counseling sessions, and these came from anecdotal evidence of other women's experience with a method, hearsay, or ill-informed advice from significant others such as family members, relatives and close friends. The management of these misconceptions during the counseling sessions on the part of the providers varied. Some managed them well while others gave responses that did not remove their fears due to lack of competence and understanding of the issues raised.

15. The concept of FPC among provider respondents is associated more with providing correct information about responsible parenthood. Ideally, it is done one-on-one with the client until a voluntary FP decision on adoption or method choice is made based on correct information. Among the stakeholders, data shows that the concept of FP counseling is more frequently associated with "information giving" or having to perform a didactic teaching function. Across the different regions considered in the study, the teaching and/or information giving functions were highlighted by the participants/respondents. Participants mentioned the need

to provide complete and accurate information about the different methods, the need to correct misconceptions, and delivering information in ways that could be easily understood by the target clients. The meeting participants from the Visayas and Mindanao regions made specific mention of GATHER as the chosen approach for FP counseling.

16. Nine (9) out of 30 -- 6 from public and 3 from private health facilities -- providers had reservations about providing FP counseling to their clients, the reasons being: (a) religious teachings; (b) lack of experience in giving counseling; (c) lack of training; and (d) limited time due to volume of patients.

17. Observations of the FP counseling sessions indicate that most of the FP counseling providers from both public and private clinics used the local dialects/languages when interacting with their clients. It is a good indication that providers are trying to make their explanations as simple as possible, to enable their clients to understand. In addition, most of the counseling sessions observed did not go beyond 45 minutes.

18. Providers and supervisors indicated that FPC is included in the goals and mission. The over-all goal/mission of the clinics covered is to provide communities with accessible, sustainable, quality and competent basic health and FP services (... at an affordable price; for private clinics only). FPC is also addressed in most clinics' performance objectives and site strategies. Interviews with supervisors also indicate that out of 28 clinics covered, only 21 clinics/centers have action plans with FP addressed in most of them; most of those who reported that they have action plans came from the private clinics. The clinic supervisors also mentioned that FP counseling is frequently integrated in the maternal health care program, specifically, in the provision of FP services, pre-natal check-ups and post-partum check-up.

19. More than half of the combined supervisors sector indicated the presence of current job vacancies at their clinics; majority of the supervisors from public health centers reported that their center's personnel and manpower are not enough, given the workload in the facility. Only 5 supervisors from the private clinics articulated the inadequacy of clinic personnel. The hiring or assignment of personnel is mostly based on certain qualifications and requirements such as training and experience; the decision is made by a higher authority (such as the City health officer and Municipal mayor/his representative; the mother organization of the private clinics also matters in the hiring of health staff).

20. Performance review of providers is mostly done by the supervisors; this is done periodically using a performance evaluation form and other indicators. The supervisors in many clinics, especially private ones, also perform clinical assessments. In addition, supervisors claimed to have been giving feedback to their staff in verbal mode (one-on–one encounter, regular meetings) rather than in non-verbal mode (memo) forms. Majority of both public and private sector providers want feedback from their supervisors, except in cases when the immediate supervisors are not available. The preferred sources of feedback were the supervisors because of their higher rank position as recognized in the clinic/center or organization. Irrespective of the type of clinics, majority of providers identified verbal feedback as the most helpful form of feedback when compared to written mode, particularly in the form of a one-on-one talk with their supervisors; feedback during meetings or group discussions was least preferred.

21. Most providers, public or private, reported to have received FP training; most of those reported not to have received any FP training at all came from the public health facilities. Public providers received the following series of training: (a) FP Counseling Training; (b)Basic/ Comprehensive Training on FP; (c) Interpersonal Communication Skills Training; and (d) Training on DMPA. This trend was also reflected among private providers, some of whom also received training from the DOH except that none have received training specifically on DMPA. They have gone through other specialized trainings, especially those organized by their own organizations/NGO's. The Basic Comprehensive Course on FP was the most liked training since it provided the needed skills to become effective FP provider. Role playing sessions and field trips during the training were also commonly cited as the best parts of the well-liked training. Among the public providers the least liked training mentioned were FP Counseling Training, followed by Interpersonal Skills Training; among private providers, it was the training on NFP, followed by Facility Management Training. The dislike in the training stems from it being hard to learn, tedious, too general in scope, and less practical when applied in actual and real life situations.

22. Twenty (20) out of thirty of the providers interviewed indicated that they still do not have all the knowledge and skill to effectively counsel clients. This is reflective of a lack of confidence among the respondents regarding their competencies and preparedness to conduct FP counseling. Thus, providers expressed the need for FP training and updates, as they claimed to have forgotten what they have learned as time passes. Providers from the public sector also reported the need for advanced training on interpersonal communication skills.

23. Most of the providers from both sectors reported a lack of FP job aids and IEC materials at the clinics. Providers expressed that certain materials should be made available. Among the materials identified were brochures, leaflets and flipcharts, and the adequate supply of contraceptives/ commodities to be used for demonstrations and/or provision when counseling is completed. The need for audio-visual aids/video was higher among the public providers. In terms of IEC/counseling materials, both public and private providers have affirmed the usefulness of the following materials: visual/physical sample of methods, brochures, flip-charts, cue cards, other FP posters, service delivery guides, models, Thiart posters and lastly, AV equipment. Most sought after in the public sector (43%) are AV equipment, physical models/samples, and cue cards.

24. Majority of providers reported running out of stock, specifically for pills and condoms, during the last 6 months. An inventory system of FP method stocks is employed by many clinics. This inventory is usually conducted every 3 months. Interviews indicate that to ensure stocks, some clinics recruit a supply officer who makes regular needs projections and fills out forms and makes orders. Keeping buffer stocks and emergency procurement were other identified solutions mentioned by both supervisors and providers.

25. Majority of both public and private providers reported an absence of mechanisms or a system to give recognition for the provider's good showing of performance. Other providers from the public sector reported the existence of reinforcers of good performance in the form of gifts/goods, bonus and cash incentives. Majority of public providers claimed that they would be motivated to perform well when provided with travel allowances and financial support, recognition and gratitude from supervisors/clients. The motivator for better performance among the private providers, on the other hand, is having better interpersonal relationships or interactions with clients, since this means more revenues and clients to serve.

26. The environment of the facility has been positively recognized by both the clients and non-clients, particularly with respect to the physical structure of the clinic. In both private and public facilities, the clients highlighted the physical condition and materials used in constructing the building, it being noted as made of concrete materials, being well-painted (colorful), and having a functional as well as stable structure. The clients also mentioned some positive attributes of the facilities such as having a quiet environment, with plants and trees, and providing enough space around the facility. The other features of the clinic environment identified by both the public and private clients were cleanliness, orderliness, and absence of foul smell. Private facilities were also commended for other features such as

having amenities like a playing area for kids, and clean comfort rooms with running water. Clients from public and private facilities cited cleanliness as an environmental attribute that they like most about the clinics/centers; they also commended the quiet and spacious environment, and use of air conditioning, among others. Private facilities were also liked because of the completeness of service and the existence of a separate room assigned primarily for FP service provision. The need for audio-visual privacy and a separate room for FP counseling use was emphasized particularly for the public sector.

Conclusions

Family planning is generally demand driven; clients' FP behavior is based on a rational and informed choice. FP clients and potential clients clearly articulate their expectations in specifying what they seek from the service providers, health centers and private clinics.

Clients of private clinics are very distinct from those of the public health facilities. Private clinics served older, highly educated and gainfully employed women and/or husbands. City health offices/centers cater to younger, moderately educated and unemployed women and/or husbands. There is not much difference seen between the characteristics of the potential clients of public health centers and those of the private clinics.

Unlike in past years, the quality of FP services currently provided by private clinics is distinct from those of the public health centers. This is clearly demonstrated in the attributes, specifically in terms of regularity and accessibility, of FP services, and the physical structure, facilities and amenities, with the private clinics providing higher quality and enjoying a much more advantaged position than those of the public health centers. Increased private sector participation in the family planning service provision seems to have started to steadily take-off in areas covered by this study.

Clients of private clinics sought an effective and permanent type of FP methods while those of the public clinics availed of varying types, from pills and DMPA to condom and natural family planning method. Family planning counseling in private clinics is provided mainly by clinical workers, while that of the public health facilities is given by both clinical and motivational workers.

In general, differences are not clearly demonstrated in the quality of family planning counseling being provided in both public and private health facilities. In addition, expectations of both the clients and potential clients did not also vary considerably. FP users in both public and private facilities articulate desired experience and expectations that address the quality areas of interpersonal relationship skills, cognitive skills, and technical competency in giving complete and accurate information about family planning; clients seem more biased toward counselors who are confident and competent in FP service provision. Potential clients generally emphasize a need for better interpersonal relationship skills and technical competency in information giving, although greater bias towards interpersonal relationship could also be gleaned.

Demand-driven behavior and rights-based orientation in FP service provision seem quite far fetched from the perspective of clients, potential clients and other stakeholders. Current views of clients and non-clients regarding the ideal behavior of a client and ideal FP counseling session seem to be directed more toward demanding for better treatment or accommodation and less for active participation in the counseling process and provider-client interaction situation. Although the addressing of questions to and/or clarifying of questions/information with the provider was reported, this type of response is not as articulated as responses on being respectful, listening, and behaving well in the clinic. Clients' and potential clients' view of an ideal counseling session refers to a situation in which they are well accommodated, greeted with a smile, and fully welcomed by the providers. Providing privacy was not much of a concern or a condition for the articulated ideal counseling setting, particularly for the clients of the public health facilities, in spite of expressed need for a separate examination and counseling room in the centers. The concept of FP counseling is much more limited to information giving together with making a decision or coming up with a specific choice of a method. There are also fewer affective/emotional FP concerns, active communication as well as exchange and question clarifications. Clients and potential clients are nonetheless concerned with the attributes of the physical and social environment of the clinics and centers. Results from stakeholders' meetings also attest to and confirm these particular findings.

In general, the actual counseling process for both public and private health facilities has left much to be desired, as results reflected gaps between what is known and what is being practiced by the providers. This is true in both public and private service providers. Much has to be done to upgrade the counseling as well as cognitive skills and technical competency in quality of care of both public and private FP counselors/providers. Clients expressed their belief that complete information about FP methods should be given to them and that they should be well-informed in order to prevent complications, correct misconceptions, and to further check rumors

circulating in the community. More importantly, adequate information-giving, correcting misconceptions with confidence and accuracy, and fears of side-effects are not well-addressed in the FP counseling process. This is demonstrated in the very low rating scores yielded by the providers.

The policy of providing quality FP counseling and quality care/service in both public and private clinics is strategically well-placed in that it is well incorporated in the mission, goals and objectives of the organization. Private clinics further advance their strategic drivers by focusing more on their operations, supervision and marketing activities. Partnerships and coordination, particularly in a referral system, are well-placed and should be further enhanced.

Support services are much more wanting in the health facilities, particularly for the public health centers. Of importance is the need to fill up existing vacancies or recruit additional personnel; to provide adequate supplies of needed IEC materials, FP supplies/commodities; and to have access to updating and refresher courses in FP and provision of quality of care training among frontline service providers. Anecdotal evidence indicates that access to an advanced type of training is being given only to heads/supervisors and not to ordinary frontline providers who need them the most. Heads/ supervisors seldom conduct a well-planned and organized echo seminar for their frontline service providers after undergoing a training. Sharing of what is acquired in the training is usually done during staff meetings.

Although supervision and a monitoring and feedback system are in existence, the manner in which these are carried out and organized is not clearly laid down and made explicit for a well-designed institutional framework. Thus, monitoring, feedback and supervision tend to be done sporadically and at times are conducted only when the head/ supervisor is available in the facility. A systematic monitoring system also leaves much to be desired. Performance indicators remain more target-oriented and unclear, making monitoring difficult and less systematic to undertake. Supportive supervision is not clearly demonstrated, although low performing providers, particularly in the private clinics, are also subject to sanctions in certain instances. The information system leaves much to be desired, particularly among the public health centers. It is not clear, however, whether available data that were gathered in both private and public health facilities are being used as bases for monitoring and improving performance.

Recommendations

Increased provision of technical and financial assistance to strengthen the capacity of public and private service providers to deliver quality family counseling must be made available. In particular, capacity building along the aspects on FP counseling, communication and provider-client interaction, addressing misconceptions as well as fears, and quality of care are imperative, particularly for direct providers and/or frontline service providers in both public and private health facilities.

The increased level of technical and financial support must vary according to the capacities, level of attained performance, and strengths of the health facilities. Private and/or NGO managed /affiliated clinics may have to be assisted in terms of further enhancing the improvement of the quality of care provision, including FP counseling, communication and provider-client interaction. This strategy might be the best way to maintain and keep their clients in a sustained manner. Since private clinics are observed to be adequately ready in providing FP quality care/service, particularly with regard to provision of a much better physical environment, more efforts will have to be concentrated on further improving the quality care and counseling process in FP service provision. Private clinics seem to be effective in serving the FP needs of the middle lower and middle level clients.

Among the public health service providers, much more is needed in terms of assistance. This has to be focused on counseling potential and new FP acceptors. Since younger and more economically deprived couples are likely to go to public health centers in seeking FP service, much assistance would have to be extended, particularly in providing a helpful and quality family planning counseling. Aside from capacity building, public health service providers need support in terms of creating an enabling physical and social environment for FP counseling; thus, some support services such as IEC materials, equipment for educational purposes, training to enhance interpersonal skills (enough to attract new users), and cognitive as well as communicative and educative skills will have to be provided. Management and handling of privacy concerns of clients need to be enhanced among public health service providers. The first line of entry to FP practice in most of the areas covered by this study still seems to be the public health centers.

To develop a common perspective and a more convergent view of what FP counseling means, the theoretical meaning of FP counseling in the FP service provision (i.e. as a normative concept; FP counseling in theory is made distinct from what is reality/actually occurring) needs to be clearly reviewed and subjected to a local critical discourse among technical consultants and

direct service providers of capacity building activities for two major reasons. **First**, stakeholders, including providers and supervisors, generally define FP counseling as mere information giving, which has a major educative function; it is basically a one-way communication process, the goal of which is to help the client come up with a decision or choice of a particular method. **Second**, the literature survey indicates that counseling has been given varying meanings; it is viewed more as either part of the broader spectrum of information exchange and/or client-provider interaction. This is imperative in order to identify and discuss thoroughly the standards of FP counseling, apart from the GATHER module. The use of the latter will have to be reviewed, noting that providers do not adhere to the sequence and that some providers just hesitate if they do not use the GATHER Module.

Partnerships between public and private providers need to be enhanced to strengthen referral systems and to intercept FP clients who have the capacity to pay for the services. One unintended outcome of the stakeholders meetings conducted by this study was the provision of an opportunity on the part of the private providers to market and disseminate information about their family planning and maternal health care services to local leaders and government officials. Some local government officials have expressed interest in working with the private service providers in providing FP quality service in their own communities with private providers in mind. More marketing and information dissemination strategies of this kind would have to be exerted by the service agents of non-government organizations.

Monitoring of quality care/service should be done regularly, and support services should be strengthened. It appears to be helpful for a separate capacity building activity, preferably at the job-site, in the area of monitoring and supervision with a focus on a broader spectrum of FP quality care/service to be conducted among the local health managers and supervisors.

An institutionalized and continued capacity building/upgrading program in FP counseling and quality care provision is needed. This should be made part of the routine management activities of the health organization and/or health facility. Since some series of FP training have already been participated in by the providers, a thorough inventory of FP and QA training needs must be done in various areas to develop more appropriate and culturally sensitive communication and client-provider interaction training modules, given various levels of the staff's knowledge or skills, and to determine those who need the training most. Fine-tuning of the modules according to the levels of involvement of the staff and their corresponding roles needs to be established. More importantly, capacity building and training activities must be conducted

on a practicum basis or on the job-site to maximize opportunities for social learning, practice and personal integration of skills learned.

The involvement and specific role that motivational workers play and the nature of their involvement in the provision of FP counseling needs to be reviewed and discussed thoroughly among the public health service providers together with their heads/ supervisors, in the light of the articulated expectations of both the clients and potential clients regarding the need for adequate and correct information about FP and the bias for competent and professional FP counselors.

Core messages in communication strategies need to focus more on the expectations of both the clients and potential clients. These pertain more to adequacy and accuracy of FP information and much better interpersonal relationships. Providing importance to persons coming into the clinics and/or health centers, and treating them humanely and warmly, are also appealing messages to project to targeted clients. Highlighting a better physical and social environment with an appropriate physical structure and adequacy of facilities and amenities is another way of attracting clients. Role modeling of males/supportive husbands might be beneficial in the information and promotional campaigns.

A program intervention related to the promotion of active participation of clients in the FP counseling process needs to be developed for both public and private users of FP. Active questioning and empowerment in the interaction process will have to be developed on the part of the clients to specifically address doubts, fears and concerns in the method choice.